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In The

Supreme Court of the United States

October Term, 1998

AMERICAN MANUFACTURERS MUTUAL INSURANCE COMPANY, *et al.*,

Petitioners,

vs.

DELORES SCOTT SULLIVAN, *et al.*,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

BRIEF FOR RESPONDENT SCHOOL DISTRICT OF PHILADELPHIA IN SUPPORT OF PETITIONERS

JAN M. RITCHIE
Counsel of Record
JAMES M. TYLER
PATRICIA FARRELL KERELO
JOSEPH W. CUNNINGHAM
MARK PFEIFFER
SCHUBERT, BELLWOAR, CAHILL & QUINN
Attorneys for Respondent School District of Philadelphia
1500 John F. Kennedy Blvd.
Suite 1400
Philadelphia, PA 19102
(215) 587-0146

4998

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QUESTIONS PRESENTED

1. Whether insurers and self-insured employers become "state actors" for purposes of the Due Process Clause when a state-authorized utilization review procedure is invoked.

2. Whether Sections 306(f.1)(5) and (6) of the Pennsylvania Workers' Compensation Act, 77 Pa. Stat. Ann. '531(5) and (6) (West Supp. 1998), which allow Pennsylvania self-insured employers and Pennsylvania insurers to delay payment of challenged medical treatment pending utilization review to determine the reasonableness and necessity of the specific treatment, comport with Due Process.

TABLE OF CONTENTS

	Page
Questions Presented	i
Table of Contents	ii
Table of Cited Authorities	v
Statement of the Case	1
A. Pennsylvania's Compelling Need For Workers' Compensation Reform	1
B. Statutory Background	4
C. Workers' Compensation Cost Containment Reform	6
a. 1993 Amendments — Act 44	6
b. 1996 Amendments — Act 57	10
c. De Novo Review	11
d. Further Appellate Review	11
D. The Civil Rights Challenge to Utilization Review	12
a. District Court Proceedings.	12
b. The Proceedings In The Court Of Appeals.	14

Contents

	Page
Summary of the Argument	15
Argument	19
I. Self-insured Employers, Like Private Insurance Companies, Do Not Become State Actors When They Elect To Use State Authorized Utilization Review Procedures Or Withhold Payment To Health Care Providers	19
II. The Utilization Review Process In Pennsylvania's Workers' Compensation System Comports With Constitutional Due Process	20
A. Claimants failed to establish a governmental deprivation of a constitutionally protected right.	20
B The Process Provides Claimants Sufficient Notice	22
C. Utilization Review Procedures Satisfy Due Process	26
a. Private Interests	27
b. Risk of Erroneous Deprivation and Alternate Procedures Would Be of No Value	29
c. Governmental Interest	32

Contents

	Page
d. The Interest Balance Weighs in Favor of the Sufficiency of the Utilization Review Process	32
D. Imposing reconsideration costs upon the losing party does not violate due process	33
Conclusion	35

TABLE OF CITED AUTHORITIES

Cases:	Page
Baksalary v. Smith, 579 F. Supp. 218 (E.D. Pa. 1984), *aff'd*, 772 F.2d 893 (3d Cir. 1985), *cert. denied*, 469 U.S. 1146 (1985)	24, 25, 26
Barns v. Lehman, 861 F.2d 1383 (5th Cir. 1988)	25
Bello v. Walker, 840 F.2 1124, 1128 (3rd Cir.), *cert. denied*, 488 U.S. 851 (1988)	22
Blum v. Yaretsky, 557 U.S. 991 (1982)	19
Board of Curators of Univ. of Missouri v. Horowitz, 435 U.S. 78 (1978)	31
Boddie vs. Connecticut, 401 U.S. 371 (1971)	33, 34
Bullock v. Carter, 405 U.S. 134 (1972)	34
Cafeteria Workers v. McElroy, 307 U.S. 886 (1961)	17, 26
Collins v. City of Harker Heights, 503 U.S. 115 (1992)	20
Cryder v. Oxendine, 24 F.3d 175 (11th Cir. 1994)	27
Fleming v. Workers' Compensation Commission of the Commonwealth of Virginia, 878 F.2d 852 (E.D. Va. 1995), *aff'd mem.*, 78 F.3d 578, *reported in full*, 1996 U.S. App. LEXIS 3858 (4th Cir. Mar. 5, 1996)	26

Table of Cited Authorities

	Page
Insurance Co. of N. Am. v. Workmen's Compensation Appeal Bd. (Kline & Packard Press), 586 A.2d 500 (Pa. Cmwlth. 1991), *aff'd*, 619 A.2d 1356 (Pa. 1993)	6
Jackson v. Metropolitan Edison Co., 419 U.S. 345 (1974)	19
Laundry Owners Mut. Liab. Ins. Ass'n. (Stop-N-Go Food Stores) v. Workmen's Compensation Appeal Board (Herpak), 617 A.2d 860 (Pa. Cmwlth. 1992), *aff'd*, 644 A.2d 697 (Pa. 1994)	6
Liberty Mut. Liab. Ins. Assoc. v. Workmen's Compensation Appeal Board, 537 Pa. 367, 644 A.2d 697 (1994)	28
Little v. Streater, 452 U.S. 1 (1981)	33, 34
Lugar v. Edmonson Oil Co., 457 U.S. 992 (1982)	20
Mathews v. Eldridge, 424 U.S. 319	15, 21, 26, 27, 28, 30, 31, 32
Midnight Sessions, Ltd. v. City of Philadelphia, 945 F.2d 667 (3d Cir. 1991) *cert. denied*, 503 U.S. 54 (1992)	27
Moats v. Workmen's Compensation Appeal Board, 588 A.2d 116, 118 (Pa. Cmwlth. 1991)	28

Table of Cited Authorities

	Page
Morrisey v. Brewer, 408 U.S. 471 (1972)	26
Mullane v. Central Hanover Bank and Trust Co., 339 U.S. 306 (1950)	24
Ortwein v. Scwab, 410 U.S. 656 (1973)	34
Parham v. J.R., 442 U.S. 584 (1979)	30, 31
Pennsylvania Macaroni Co., Inc. v. Workmen's Compensation Appeal Board, 387 A.2d 949 (Pa. Cmwlth. 1978)	6, 21
Richardson v. Perales, 402 U.S. 389 (1971)	30
School Dist. of San Antonio v. Rodriguez, 411 U.S. 1 (1973)	34
Shapiro v. Thompson, 394 U.S. 618 (1969)	34
Skinner v. Oklahoma ex rel. Williamson, 316 U.S. 535 (1942)	34
United States v. Kras, 409 U.S. 434 (1973)	34
Walters v. National Ass'n of Radiation Survivors, 473 U.S. 305 (1985).	26, 27
Werz v. Workmen's Compensation Appeal Board (Dep't. of Corrections), 683 A.2d 1287 (Pa. Cmwlth. 1996), *appeal denied*, 690 A.2d 1165 (Pa. 1997)	5

Table of Cited Authorities

	Page
Williams v. Rhodes, 393 U.S. 23 (1968)	34
Winterberger vs. CNA Ins. Co., 72 F.3d 318 (3d Cir. 1995)	4
Statutes:	
34 Pa. Code 121.23(a)	6
34 Pa. Code § 127.208	7, 21, 22, 25
34 Pa. Code § 127.208(f)	10, 11, 21
34 Pa. Code § 127.401	25
34 Pa. Code § 127.401(b)	8
34 Pa. Code § 127.402	25
34 Pa. Code § 127.403	8
34 Pa. Code § 127.413(a)	25
34 Pa. Code §§127.451	7
34 Pa. Code § 127.452	7, 23
34 Pa. Code § 127.453(a)	8
34 Pa. Code § 127.453(b)	8, 23

Table of Cited Authorities

	Page
34 Pa. Code § 127.454	8
34 Pa. Code § 127.455	8
34 Pa. Code § 127.457	9
34 Pa. Code § 127.459	9, 30
34 Pa. Code § 127.460	9, 30
34 Pa. Code § 127.461	9, 30
34 Pa. Code § 127.465	9
34 Pa. Code § 127.466	9, 29
34 Pa. Code §127.467	9, 29
34 Pa. Code § 127.469	9, 30
34 Pa. Code § 127.470	9, 23
34 Pa. Code § 127.470(a)	29
34 Pa. Code § 127.470(b)	29
34 Pa. Code § 127.471	9, 23
34 Pa. Code § 127.471(b)	10
34 Pa. Code § 127.472	10, 22

Table of Cited Authorities

	Page
34 Pa. Code § 127.473	10
34 Pa. Code § 127.476	9, 10, 22
34 Pa. Code § 127.477	10
34 Pa. Code § 127.479	10
34 Pa. Code § 127.501	10, 22
34 Pa. Code § 127.502	10, 22
34 Pa. Code §§ 127.503-127.515	10
34 Pa. Code § 127.505	10
34 Pa. Code § 127.505(b)	10
34 Pa. Code§ 127.509	10
34 Pa. Code § 127.514(a)	11, 18, 34, 35
34 Pa. Code § 127.551	11
34 Pa. Code § 127.552	11
34 Pa. Code § 127.553	11
34 Pa. Code § 127.554	11
34 Pa. Code § 127.555	11

Table of Cited Authorities

	Page
34 Pa. Code § 127.556	11
34 Pa. Code § 127.651-670	29
42 Pa. C.S. § 751	22
42 Pa. C.S. § 761	12, 31
63 Pa. Stat. Ann. § 422.41	7
77 Pa. Stat. Ann. § 1 *et seq.*	1
77 Pa. Stat. Ann. § 27	5
77 Pa. Stat. Ann. § 221	5
77 Pa. Stat. Ann. § 241	21
77 Pa. Stat. Ann. § 283	21
77 Pa. Stat. Ann. § 301	21
77 Pa. Stat. Ann. § 422.1	7
77 Pa. Stat. Ann. § 431	4
77 Pa. Stat. Ann. § 481	4
77 Pa. Stat. Ann. § 501	5
77 P.S. §§ 511-516	4
77 P.S. § 531	4

	Page
77 Pa. Stat. Ann. § 531(2)(ii)	5, 6
77 Pa. Stat. Ann. § 531(5)	i, 1, 7
77 Pa. Stat. Ann. § 531(6)	i, 1, 7, 18, 22
77 Pa. Stat. Ann. § 531(6)(iii)	34
77 Pa. Stat. Ann. § 531(6)(iv)	11, 22
77 Pa. Stat. Ann. § 701 (West Supp. 1998)	11
77 Pa. Stat. Ann. § 711	5
77 Pa. Stat. Ann. § 717.1	27
77 Pa. Stat. Ann. §717.1(a)	11
77 Pa. Stat. Ann. § 731	5
77 Pa. Stat. Ann. § 833	11
77 Pa. Stat. Ann. § 834	11
77 Pa. Stat. Ann. § 854-855	12
77 Pa. Stat. Ann. § 996	11
77 Pa. Stat. Ann. § 999	28
77 Pa. Stat. Ann. § 999(a)	6

	Page
77 Pa. Stat. Ann. § 2221	21
77 Pa. Stat. Ann. § 5531(5-6)	19
42 U.S.C. § 1983	12, 13, 15, 20
United States Constitution:	
Eleventh Amendment	15
Fourteenth Amendment	
Rules:	
Pa. Legis. J. — House 18 (March 30, 1993)	1
Pa. Legis. J. — House 542	3
Pa. Legis. J. — House 543	3, 4
Pa. Legis. J. — House 544 (March 30, 1993)	2, 4
Pa. Legis. J. — House 1504-1505 (June 24, 1993)	3
Pa. Legis. J. — House 2015 (December 11, 1991)	1
Pa. Legis. J. — House 2019 (December 11, 1991)	1, 4
Pa. Legis. J. - House 2020 (December 11, 1991)	4
Pa. Legis. J. — Senate 283	2

Table of Cited Authorities

	Page
Pa. Legis. J. — Senate 284	32
Pa. Legis. J. - Senate 472 (April 19, 1993)	2
Pa. Legis. J. — Senate 473 (April 19, 1993)	1
Pa. Legis. J. — Senate 1044-1045 (June 16, 1993)	1, 20
Pa. Legis. J. — Senate 1046 (June 16, 1993)	1
Fed. R. Civ. P. 12(c)	14
Fed. R. Civ. P. 54(b)	14
Pa. R. Civ. P. 1001-1041.2	35
Pa. R. Civ. P. 1017	35
Pa. R. Civ. P. 1028	35
Pa. R. Civ. P. 1029	35
Pa. R. Civ. P. 1030	35
Pa. R. Civ. P. 3101-3149	35

STATEMENT OF THE CASE

A. Pennsylvania's Compelling Need For Workers' Compensation Reform

Prior to the enactment of cost containment initiatives amending Pennsylvania's Workers' Compensation Act, Act of June 2, 1915, P.L. 736, *as amended*, 77 Pa. Stat. Ann. § 1 et seq. (West Supp. 1998) (hereinafter "Act"), the School District of Philadelphia (hereinafter "School District"), among other Pennsylvania employers, confronted soaring costs of mandatory workers' compensation.[1] The high cost of workers' compensation insurance was crippling, prohibiting industries from competing successfully in Pennsylvania. Pa. Legis. J. - Senate 472 (April 19, 1993). It is indisputable that jobs were lost every day due to workers' compensation costs. Pa. Legis. J. — Senate 1046 (June 16, 1993).

In 1993, prior to the amendments to the Act, the costs to insurers of workers' compensation was approximately $23 million. Pa. Legis. J. — House 18 (March 30, 1993). There were concerns regarding whether the State Workers' Insurance Fund (hereinafter "SWIF") was actuarially sound. Pa. Legis. J. — House 2015 (December 11, 1991). Discussion indicated that SWIF, which insured approximately 450,000 employees working for approximately 35,000 Pennsylvania employers, was on the verge of bankruptcy and operating at a loss. Pa. Legis. J. — Senate 1044-1045 (June 16, 1993); Pa. Legis. J. — Senate 473 (April 19, 1993).

The Commonwealth's General Assembly witnessed the exodus of business. Pennsylvania Bureau of Workers' Compensation, Annual Report, 1996-1997 (hereinafter "Annual Report") at ii; News Brief from the Office of Governor Tom Ridge, Vol. 1, Issue 8 (May 31, 1996); <http.//www.state.pa.us/pa_exec/governor/news_briefs/ Vol1iss8.html>. News Brief from the Office of Governor Tom Ridge, Vol 1, Issue 7 (May 24, 1996). <http.//www.state.pa.us/pa_exec/governor/news — briefs/ Vol1iss7.html>. Other states, including Ohio and West Virginia, were funding efforts to identify Pennsylvania businesses that were disenchanted with the business climate of Pennsylvania and attract these businesses to their respective states. Pa. Legis. J. — House 2019 (December 11, 1991).

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1. The relevant cost containment provisions of the Act of July 2, 1993, P.L. 190, No. 44, appear in Section 306 (f.1) (5) and (6) of the Act, 77 Pa. Stat. Ann. ' 531 (5) and (6) (West Supp. 1998) (hereinafter "Act 44").

Employers who fled the Commonwealth for more business-friendly states attributed the reason for relocation to accelerating economic decline due to workers' compensation losses.[2] Annual Report at ii; News Brief from the Office of Governor Tom Ridge, Vol. 1, Issue 8, (May 31, 1996); <http.//www.state.pa.us/pa_exec/governor/news_briefs/Vol1iss8.html>. News Brief from the Office of Governor Tom Ridge, Vol. 1, Issue 7 (May 24, 1996). <http.//www.state.pa.us/pa_exec/governor/news_briefs/Vol1iss8.html>.

Not surprisingly, the Pennsylvania legislature debated and ultimately passed cost containment initiatives with the express intention of greatly

2. The legislative history of Act 44 is replete with examples of inequities the pre-Act 44 workers' compensation system worked upon Pennsylvania employers and the compelling need for change. For example, Senator Mowery in noting the severity of the workers' compensation problem in Pennsylvania observed that one particular Pennsylvania company reported that it would pay between $275,000 and $330,000 more in insurance premiums in Pennsylvania then it would be required to pay in the surrounding states of New Jersey, Maryland and Virginia. Pa. Legis. J. — Senate 283 (February 10, 1993). Senator Madigan reported that a publishing industry relocated to Kansas because workers' compensation issues were the "straw[s] that broke their back." *Id.* Senator Madigan also reported that 350 union jobs were being lost to the State of Indiana as the result of the high cost of workers' compensation; and that 129 steelworkers' jobs were lost due to workers' compensation costs. *Id.*

One senator, Senator Peterson, reported that he was losing business almost weekly "laying at the feet of workmen's comp." Describing one such business that had recently closed its doors, he stated ". . . 55 people no longer have a job because of a workmen's comp system that is bankrupting the employers of this Commonwealth." Pa. Legis. J. — Senate 472 (April 19, 1993). Senator Peterson urged passage of meaningful reform to remedy the workers' compensation problem to preserve Pennsylvania jobs. *Id.* 472-473.

In the Pennsylvania House of Representatives, Representative Clymer discussed a small manufacturing business employing 15 people. Pa. Legis. J. — House 544 (March 30, 1993). The business cited a 188% increase in workers' compensation over the 5 years proceeding 1993. *Id.* He also reported that Bucks County, Pennsylvania, lost 50 manufacturing jobs to Florida with one of the reasons being inability to deal with workers' compensation. *Id.*

Representative Dent reported 48 jobs were moving from the City of Bethlehem, Pennsylvania, to Camden, New Jersey. *Id.* at 547. He also related that a plant relocated to Virginia and 220 jobs were lost from his district. The only reason publicly stated for the job loss was the fact that Pennsylvania's workers' compensation system was "just atrocious". This business paid nearly $500,000.00 in workers' compensation in Pennsylvania and only $3,000.00 in Virginia. *Id.* at 547.

curtailing the escalating health care costs in the treatment of work-related injuries and disease. Department of Labor and Industry, Workers' Compensation Medical Cost Containment, Pennsylvania Bulletin, (Vol. 24, No. 30, July 23, 1994); Department of Labor and Industry, Bureau of Workers' Compensation, Amendments to the Workers' Compensation Act, Pennsylvania Bulletin, (Vol. 23, No. 35, August 28, 1993). The General Assembly acted to amend the workers' compensation system to more fairly balance the interests of workers injured at work (hereinafter "claimants") and employers in an effort to ensure an affordable compensation system for Pennsylvania. Pa. Legis. J. — House 542 (March 30, 1993), (referencing numerous letters regarding the need for workers' compensation reform); *see also* Pa. Legis. J. — House 1504-1505 (June 24, 1993) (need for governor, insurance department and legislature to act to cap medical costs and prevent rate hike).

In the midst of spirited debate regarding the best way to keep needed business in Pennsylvania, Representative Joseph Gladeck discussed at length the history of Pennsylvania's Workers' Compensation Act. Representative Gladeck addressed the Commonwealth's adoption, in 1972, of the report and recommendations of the National Commission on Workers' Compensation. The recommendations were issued after the enactment of the Federal Occupational Safety and Health Act in 1970. Pa. Legis. J. — House 543 (March 30, 1993). Representative Gladeck explained that this report substantially expanded benefits for claimants. The changes represented a fundamental alteration to the historical compromise underpinning the workers' compensation system. The system stemmed out of an arrangement where employees gave up their right to sue in exchange for being provided a fixed wage loss benefit upon the occurrence of an identifiable accident at work. *Id.*

The expansion of benefits included changes from coverage for accidents to coverage for injuries thus including "soft tissue", repetitive and occupational disease as injuries under the Act; changed wage loss benefits by substantially expanding them and providing for annual adjustment in the maximum amount; and changed the Act to provide unlimited medical coverage. *Id.* After the dramatic change to substantial benefits in 1972, the Commonwealth experienced a growth trend that increased rapidly. By the early 1990's, it was projected that the cost of the expanding workers' compensation program would overwhelm

Pennsylvania's economy, businesses and citizens if not dealt with.[3] *Id.* at 543. As Representative Gladeck pointed out, the changes being discussed, which were ultimately included in Act 44, did nothing to alter the range of the expanded benefits given to claimants' in 1972 and only sought to make those benefits affordable. *Id.*

The Pennsylvania legislature also recognized that the rising costs of the medical aspect of workers' compensation was an avenue of expense that could be controlled. It was noted that $400,000,000 of medical costs were saved in automobile insurance by capping and pro-rating by the insurance department; the federal government capping health care with "DRGs" (diagnostic related grounds); and the "*Blues*" (Blue Cross/ Blue Shield health coverage) capping health care in accordance with the automobile insurance medical cost caps. Pa. Legis. J. — House 2019-2020 (December 11, 1991). The legislative perception was that health care abuse was moving to workers' compensation because it was the only major medical system that was unregulated. *Id.*

Accordingly, it is readily apparent from review of the legislative history of Act 44 that in implementing the cost-containment initiatives, the Pennsylvania legislature intended to balance inequities and provide a system that protects not only claimants but employers in Pennsylvania as well.

B. Statutory Background

The Act establishes a required insurance system to provide compensation to employees who sustain injuries in the course of and related to their employment. It provides the exclusive means by which an employee may recover against employers for work-related injuries. 77 Pa. Stat. Ann. § 481; *Winterberger vs. CNA Ins. Co.*, 72 F.3d 318 (3d Cir. 1995). Compensation under the Act is payable without regard to negligence. 77 Pa. Stat. Ann.§ 431.[4]

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3. Particularly emphasized were the concerns that businesses were not expanding because of high workers' compensation rates; businesses were closing because they could not absorb the costs of workers' compensation; businesses were fleeing the state to surrounding states with more equitable compensation systems; and Pennsylvania citizens were losing jobs and facing unemployment due to the costs. *Id.* at 544.

4. Both wage replacement payments, which are contingent on a continuing wage loss due to a work injury, and payment for reasonable medical services are benefits payable under the Act. 77 P.S. §§ 511-516, 531.

The Act requires employers to either obtain insurance or self-insure liability under the Act. 77 Pa. Stat. Ann. § 501. Employers who do not self-insure may obtain insurance from any insurance carrier authorized to write workers' compensation policies within Pennsylvania, including the State Workman's Insurance Fund ("SWIF"). SWIF was created by the Pennsylvania General Assembly to provide coverage to any employers who request it. 77 Pa. Stat. Ann. § 221, 501. When insured, the insurer merely "assume[s] the employer's liability [t]hereunder and shall be entitled to all of the employer's immunities and protection. . . ." 77 Pa. Stat. Ann. § 501.

Pennsylvania's compensation system is administered by the Department of Labor and Industry, through its Bureau of Workers' Compensation (the "Bureau"). 77 Pa. Stat. Ann. §§ 27, 711. The compensation scheme provides three methods by which an employer pays compensation. The employer may file a Notice of Compensation Payable with the Department of Labor and Industry; enter into an agreement with the injured claimant to pay compensation; or pay pursuant to an order of a Workers' Compensation Judge where an employee's claim petition has been granted. 77 Pa. Stat. Ann. § 731.

Prior to the enactment of the medical cost containment provisions of Act 44 in 1993, and the legislative refinement of the process in 1996 under Act 57, Pennsylvania employers and insurers were required to pay all medical bills that a physician or other licensed practitioner of the healing arts submitted with a report until such time as a workers' compensation referee (later defined "workers' compensation judge") ruled upon any challenge to that treatment. 77 Pa. Stat. Ann. § 531(2)(ii). Employers were required to have a reasonable basis to contest the bills (i.e., a medical opinion that the bills were not reasonable or necessary) before filing petitions to challenge injured employees' entitlement to receipt of the benefits, 77 Pa. Stat. Ann. § 996;[5] and the Act expressly prohibited the workers' compensation referees from granting a supersedeas or stay of the payment of medical bills while a challenge to treatment was pending review. 77 Pa. Stat. Ann. § 531(2)(ii).

If an employer or insurer were to prevail on a review petition, the Supersedeas Fund, created by annual assessments on Pennsylvania

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5. *Werz v. Workmen's Compensation Appeal Board (Dep't. of Corrections)*, 683 A.2d 1287 (Pa. Cmwlth. 1996), *appeal denied*, 690 A.2d 1165 (Pa. 1997). Employers remain obligated to maintain a reasonable contest under Act 44 and 57, as well.

employers and insurers, was available for reimbursement. *Insurance Co. of N. Am. v. Workmen's Compensation Appeal Bd. (Kline & Packard Press)*, 586 A.2d 500 (Pa. Cmwlth. 1991), *aff'd*, 619 A.2d 1356 (Pa. 1993); *Pennsylvania Macaroni Co., Inc. v. Workmen's Compensation Appeal Board*, 387 A.2d 949 (Pa. Cmwlth. 1978). However, the Supersedeas Fund only reimbursed the value of those medical bills (without interest) which were paid after filing a review petition challenging the reasonableness and necessity of treatment. 77 Pa. Stat. Ann. § 531(2)(ii) and 999(a). *See, e.g., Laundry Owners Mut. Liab. Ins. Ass'n. (Stop-N-Go Food Stores) v. Workmen's Compensation Appeal Board (Herpak)*, 617 A.2d 860 (Pa. Cmwlth. 1992), *aff'd*, 644 A.2d 697 (Pa. 1994) (recognizing that medical expenses, but not interest, can be reimbursed by the Supersedeas Fund for payments made pending final outcome of the case).

Repeatedly, employers found that even their own proportionate share of funds paid into the Supersedeas Fund were not fully available to them when extensive unreasonable and unnecessary treatment was rendered prior to the submission of bills to employers.[6] *Laundry Owners Mut. Liab. Ins. Ass'n.* In such situations the most the employer who challenged the bills through a review petition would ultimately be entitled to receive from the fund was the value of any bills paid following the filing of the petition. For example, if unreasonable and unnecessary surgery was performed and enormous bills were submitted, the employer would be forced to pay for that surgery. If ultimately successful on a petition to review medical treatment, the employer would only recoup from the fund the costs of any follow up provided after the employer secured an opinion that the surgery was not reasonable and necessary and then filed a petition with the Bureau.

C. Workers' Compensation Cost Containment Reform

a. 1993 Amendments — Act 44

On July 2, 1993, the Pennsylvania Legislature passed various amendments to the Workers' Compensation Act which were specifically intended to contain the spiralling medical costs associated with work-related injuries. *See also* Department of Labor and Industry, Bureau of

6. Employers and insurers are annually assessed for the Supersedeas Fund pursuant to a formula set forth at 34 Pa. Code 121.23(a). The formula requires the assessment to be 100% of the amount reimbursed to insurers and self-insurers in the proceeding year.

Workers' Compensation, Act 44; Pennsylvania Bulletin, (Vol. 25, No. 45, November 11, 1995). One of these amendments was the creation of the utilization review process, a non-adversarial administrative process which allows for the review of the reasonableness or necessity of medical treatment being received by a claimant. Section 8 of Act 44, renumbered as 306 (f.1) (5) and (6), and amended, 77 Pa. Stat. Ann. § 531 (5) and (6).

Where the utilization review process is invoked, the Act "tolls" the requirement that employers or insurers must pay for medical treatment within 30 days of receipt of the bill by the provider. 77 Pa. Stat. Ann. § 531(5) as further defined in 34 Pa. Code § 127.208. A claimant, employer or insurer may invoke the utilization review process by submitting to the Bureau of Workers' Compensation a request for review of specified treatment on a form prescribed by the Bureau. 34 Pa. Code §§ 127.451, 127.452. The request must be served upon all parties including the claimant, employer, insurance company and medical provider. 34 Pa. Code § 127.452. The Act does not suspend, nor does it require, medical providers to stop providing the challenged treatment to claimants.[7]

7. Physicians are ethically required to continue treatment. The Medical Practice Act of 1985, Act of December 20, 1985, P.L. 457, No. 112, 77 Pa. Stat. Ann. § 422.1 *et seq.* (hereinafter "Medical Practice Act), prohibits unprofessional conduct by physicians. The term "unprofessional conduct" includes "departure from or failing to conform to an ethical or quality standard of a profession." 63 Pa. Stat. Ann.. § 422.41.

The American Medical Association has issued the following ethical guidance concerning continuity of patient care:

> 5. The patient has the right to continuity of healthcare. The physician has an obligation to cooperate in the coordination of medically indicated care with other healthcare providers treating the patient. The physician may not discontinue the treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable assistance and sufficient opportunity to make alternative arrangements for care.
> 6. The patient has a basic right to have available adequate healthcare. Physicians, along with the rest of society, should continue to work toward this goal. Fulfillment of this right is dependent upon society providing resources so that no patient is deprived of necessary care because of inability to

(Cont'd)

A review request is assigned by the Bureau to a utilization review organization ("URO"). 34 Pa. Code §§ 127.403, 127.453(a). Utilization review organizations consist of impartial medical or health care providers authorized by the Secretary of Labor and Industry to conduct utilization reviews.[8] 34 Pa. Code § 127.401(b). All parties and their legal counsel, if known, are advised of the utilization review organization assignment by the Bureau. 34 Pa. Code § 127.453(b). If a utilization review organization cannot perform the review request assigned to it for any reason, it must notify the Bureau and return the request to the Bureau for reassignment. 34 Pa. Code § 127.454. Where the utilization review organization has a conflict of interest, the matter must be reassigned. 34 Pa. Code § 127.455.

(Cont'd)

> pay for the care. Physicians should continue their traditional assumption of a part of the responsibility for the medical care of those who cannot afford essential healthcare. Physicians should advocate for patients in dealing with third parties when appropriate.

American Medical Assn., Report of the Council on Ethical and Judicial Affairs, Fundamental Elements of the Patient-Physician Relationship (1994), <http://www.ama-assn.org/ethic/fundelms.htm>.

The Office of General Counsel of the American Medical Association has issued the following guidance with regard to ending patient/physician relationships:

> Once a patient-physician relationship has begun, a physician is generally under both an ethical and legal obligation to provide the services as long as the patient needs them . . . according to the AMA's Council on Ethical and Judicial Affairs, a physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable notice and sufficient opportunity to make alternative arrangements for care. Further, the patient's failure to pay a bill does not end the relationship, as the relationship is based on a fiduciary, rather than a financial responsibility.

American Medical Assn., Office of the General Counsel, Div. of Health Law, Ending the Patient-Physician Relationship (1994), <http://www.ama-assn.org/physlegl/legal/termrel.htm>.

8. Standards for reviewers include the requirement of licensure in the same profession and specialty as the provider under review. For reconsideration, the providers were required to be board-certified in the specialty. All reviewers are also required to maintain an active clinical practice. July 23, 1994 Pennsylvania Bulletin.

If the utilization review organization retains the assignment, it must request the records of the treating providers within 5 days from receipt of the assignment. 34 Pa. Code § 127.457. Only the records of actual treating health care providers (the provider under review and other treating providers) may be obtained by the utilization review organization. 34 Pa. Code §§ 127.459, 127.460. Utilization review organizations may not request and cannot be supplied with reports of independent medical examinations performed at the request of an insurer, employer, claimant or attorney. 34 Pa. Code § 127.461. Although an insurer or employer may initiate the utilization review process, they have no evidentiary input and provide no independent information which may influence or affect the ultimate determination. The utilization review is only based upon the treating providers' records and the discussions, if any, the reviewer has with the provider under review. *Id*; 34 Pa. Code § 127.469. The provider under review must be given the opportunity to discuss the challenged treatment with the reviewer. *Id.*

The reviewer must have the same profession and specialty as the provider under review and shall apply the generally accepted treatment protocols to the case. 34 Pa. Code §§ 127.466, 127.467. The sole issue to be determined by the reviewer is whether the treatment under review is reasonable or necessary for the claimant's medical condition. Causation and "work-relatedness" must be assumed by the reviewer. 34 Pa. Code § 127.470. The "reasonable or necessary" finding must be definite and not advisory. 34 Pa. Code § 127.471. The reviewer is not to decide whether the claimant is disabled, whether maximum medical improvement has been obtained, or comment upon the quality of care or the reasonableness of the fees. 34 Pa. Code § 127.470. Thus, questions of causality remain within the exclusive jurisdiction of workers' compensation judges.

The utilization review organization must complete its review and render its determination within 30 days of a completed utilization request. 34 Pa. Code § 127.465. A "completed" request occurs upon the utilization review organization's receipt of medical records or 35 days from the date of notice of the assignment, whichever is earlier. *Id.*

The utilization review organization advises the claimant of the reviewer's determination and the basis therefore and provides the appropriate forms for claimants to seek further review.

Either the form for reconsideration or a petition for review is served with the determination on all parties and the claimant's attorney, if known. 34 Pa. Code § 127.476.

The reviewer's written report must include a list of records reviewed; documentation of actual or attempted contacts with the provider under review; the findings and conclusions of the reviewer; a detailed rationale for those conclusions, with citations to generally accepted treatment protocols and medical literature as appropriate. 34 Pa. Code § 127.472. Determinations must be explicit and final. If, there is medical doubt in the reviewer's mind, that doubt must resolve in favor of the treating provider. 34 Pa. Code § 127.471(b).

The report must be signed and verified by the reviewer, and then served upon the Bureau and all parties. 34 Pa. Code §§ 127.473, 127.476.

The employer or insurer pays for the initial utilization review regardless of who requested the review or the outcome. 34 Pa. Code § 127.477. If the reviewer determines the treatment is reasonable and necessary, the employer must pay the bill irrespective of its intention to challenge the treatment further on appeal.[9] 34 Pa. Code § 127.208(f).

b. 1996 Amendments — Act 57

Subsequent to the institution of the instant case, the Act was amended. Act of June 24, 1996, P.L. 350, No. 57 (hereinafter "Act 57"), which became effective August 23, 1996, eliminated the reconsideration level of the utilization review process. Prior to Act 57, any party dissatisfied with the outcome of the initial utilization review could file with the Bureau, on one of its prescribed forms, a request for reconsideration. 34 Pa. Code §§ 127.501, 127.502. The reconsideration request had to be filed within thirty days of receipt of the initial utilization review determination. *Id.*

Under pre-Act 57 procedures, the Bureau then forwarded the reconsideration request to the utilization review organization which conducted the initial review. 34 Pa. Code § 127.505. All parties were given notice of the assignment. 34 Pa. Code § 127.505(b). The reconsideration review would then be assigned by the utilization review organization to a reviewer other than the initial reviewer. 34 Pa. Code § 127.509. The reconsideration process then proceeded in a manner substantially similar to the initial utilization review process. 34 Pa. Code §§ 127.503-127.515.

The Bureau would advance the costs of the reconsideration and later bill the "losing party", who was identified applying the criteria enumerated

9. Prior to Act 57, if the challenged treatment was found reasonable or necessary by the initial reviewer, the employer or insurer had to pay the provider's bills unless it requested reconsideration of the decision. 34 Pa. Code § 127.479.

in the regulations. 34 Pa. Code § 127.514(a). However, the payment of the costs imposed was not required before the losing party could file a petition for review before a Workers' Compensation Judge.

Any party dissatisfied with the reconsideration determination could file a petition for review with the Bureau within 30 days of the utilization review organization reconsideration determination. 77 Pa. Stat. Ann. § 531(6)(iv); 34 Pa. Code §§ 127.551-127.556. If the challenged treatment was found to be reasonable or necessary on reconsideration, the employer or insurer was required to pay for it even if a petition for review was filed. 34 Pa. Code § 127.208(f).

c. De Novo Review

Before Act 57's passage, after reconsideration, a dissatisfied party could petition for a de novo hearing before a Workers' Compensation Judge. 34 Pa. Code § 127.551-556. Due to Act 57's elimination of the reconsideration step, a dissatisfied party may now file such a petition directly with the workers' compensation judge from the initial utilization review decision. *Id.*

The petition for review of utilization review determination procedures before the Workers' Compensation Judge are essentially the same now as they were prior to Act 57. The petition is assigned to a Workers' Compensation Judge for a hearing de novo. 34 Pa. Code §§ 127.553-127.556. The judges are appointed by the Secretary of Labor and Industry to hold hearings. 77 Pa. Stat. Ann. § 701 (West Supp. 1998). They are empowered to subpoena witnesses, order the production of documents, and hear evidence on petitions assigned to them. 77 Pa. Stat. Ann. § 833. Judges must base their findings of fact on sufficient, competent evidence. 77 Pa. Stat. Ann. § 834 (West Supp. 1996). In addition to findings of fact, their decisions must contain conclusions of law and a concise explanation of the rationale for the decision reached. *Id.*

If an employee prevails on the petition for review of utilization review decision, the employee is entitled to an award of benefits plus 10% interest. 77 Pa. Stat. Ann. § 717.1(a) (West Supp. 1998)). A claimant may also recover litigation costs. 77 Pa. Stat. Ann. § 996 (West Supp. 1998).

d. Further Appellate Review

Any dissatisfied party may appeal a Workers' Compensation Judge's decision to the Workers' Compensation Appeal Board (hereinafter the "Board"). 77 Pa. Stat. Ann. § 701. The Board reviews the decision for

errors of law and to determine whether findings of fact are supported by substantial evidence. 77 Pa. Stat. Ann. §§ 854-855. The Board's decisions are appealable as of right to the Commonwealth Court of Pennsylvania. 42 Pa. C.S. § 761.

D. The Civil Rights Challenge to Utilization Review

Ten employees claiming entitlement to workers' compensation benefits initiated this civil rights action pursuant to 42 U.S.C. § 1983, challenging the process for reviewing the reasonableness and necessity of medical treatment under the utilization review process enacted in 1993 amending the Act. The Philadelphia Area Project on Occupational Safety and Health, an organization which advocates on behalf of claimants; and the Philadelphia Federation of Teachers, a labor union which represents employees of the Philadelphia School District also were included as Plaintiffs. C.A. App. A74-A120. The claims were brought on behalf of a class of workers' compensation claimants who allege to have had or in the future will have payment for some or all of their medical treatment suspended during the utilization review process that is being challenged.[10] *Id.*

The defendants include various state officials responsible for administering portions of the workers' compensation system, several private insurance carriers which issue workers' compensation policies (Petitioners in this matter hereinafter referred to as "insurers") and the School District. The School District was the sole self-insured defendant named in the class action suit. C.A. App. A74-A120, A163-A196.

The questions presented to this Honorable Court in the order of importance to the Commonwealth of Pennsylvania as a whole are whether the Utilization Review procedures as set forth in the cost containment initiatives of the Pennsylvania workers' compensation act violate the Fourteenth Amendment to the United States Constitution; and whether private insurance companies or self-insured employers become state actors and subject to civil damages for purposes of the due process clause when they elect to use the state-authorized cost containment procedure.

a. District Court Proceedings.

Plaintiffs' original complaint alleged that the 1993 amendments to the Act ("Act 44") violated constitutional due process in allowing for the

10. No class was certified, although Plaintiffs moved the trial court for class certification on May 28, 1996. C.A. App. A12.

suspension of medical benefits without prior notice to the employee and an opportunity to be heard. C.A. App. A164-A196. The Complaint asserted that pursuant to Section 306(f.1)(5) of Act 44, insurers or self-insured employers may seek utilization review of the reasonableness and necessity of medical treatment received by claimants. C.A. App. A174-A175. Plaintiffs alleged that the initiation of the utilization review process operated as an "automatic supersedeas" which allowed the insurers or employers to stop paying for the treatment pending the review. C.A. App. A175.

Plaintiffs asserted that the insurers and School District violated their due process rights by suspending the payment of medical benefits during the pendency of the utilization review process. C.A. App. A179. The Complaint further alleged that the Commonwealth officials also violated Plaintiffs' due process rights by participating in the utilization review process and failing to prohibit insurers from suspending the payment of medical benefits pending review. *Id.*

The insurers and the School District filed motions to dismiss the original Complaint, including the claims of Susan Hansen. C.A. App. A9. In their motion, the insurers argued that invoking the utilization review process did not constitute "state action" as required by Section 1983. The School District moved for dismissal on the grounds that it could not be sued for violations of the Due Process Clause of the Fourteenth Amendment under 42 U.S.C. § 1983 because it did not promulgate any policies or procedures or develop any standard operating practice pertaining to utilization review that could have caused a deprivation of plaintiff Susan Hansen's constitutional rights. The School District argued in its motion that its third party administrator invoked the process and decided to suspend payment, without specific direction from the School District and, therefore, no "state action" was present. C.A. App. A56, A72-A73.

In a May 8, 1995 Order, the District Court granted Plaintiffs' request for discovery on the issue of "state action". C.A. App. A9. After discovery, Plaintiffs filed a motion for partial summary judgment against the insurers and the School District. C.A. App. A10. In a January 24, 1996 Order, the District Court denied Plaintiffs' motion; denied the School District's motion to dismiss; and granted the insurer's motion to dismiss. C.A. App. A48. The Court found that the insurers were not "state actors" and denied the School District's motion, holding that more discovery on the state action issue was warranted. C.A. App. A72-A73. Plaintiffs'

subsequent motion for a final order under Rule 54(b) and motion for reconsideration were denied. C.A. App. A11.

On or about May 21, 1996, Plaintiffs filed an Amended Complaint which added several new parties and claims. C.A. App. A74-A120. Plaintiffs reiterated their due process challenge to the procedures surrounding the suspension of payment of medical benefits during the utilization review process. They also asserted that Act 44 violated substantive and procedural due process in imposing the cost of reconsidering the initial review decision on the losing party. In addition, Plaintiffs claimed that the Commonwealth officials violated procedural due process in failing to promulgate regulations governing Workers' Compensation Judges' adjudication of petitions for review of utilization review decisions. *Id.*

On or about June 20, 1996, the Commonwealth officials filed a motion to dismiss the Amended Complaint. C.A. App. A12-A13. By Order and Memorandum entered November 8, 1996, the District Court granted the Commonwealth officials' motion, determining that the Workers' Compensation Act comports with due process. C.A. App. A17-A44. Based upon this Order and Memorandum, the School District filed a motion for judgment on Plaintiffs' Amended Complaint pursuant to Fed. R.Civ.P. 12(c). C.A. App. A14. By Order dated December 13, 1996 and entered December 16, 1996, the District Court granted the School District's motion. C.A. App. A16. Plaintiffs appealed to the United States Court of Appeals for the Third Circuit.

b. The Proceedings In The Court Of Appeals.

The Third Circuit reversed the District Court's rulings on the insurer's summary judgment motion as well as the Commonwealth's summary judgment motion. Pet. App. 1a-40a. In doing so, the Third Circuit erroneously equated the cost containment feature of the utilization review provisions allowing the tolling of the required time for payment of medical bills under the Act, with a supersedeas on a claimant's entitlement to any or all medical treatment pending review and, thus, violative of the employee's due process rights. The court determined that the claimants were not given adequate notice that their benefits may cease after a utilization review is invoked and were not provided an opportunity for written input to the utilization reviewer prior to the "termination" of benefits taking effect. Pet. App. 21a-25a, 30a-33a.

The Court also found that the private insurance companies were state actors and could be joined in a Section 1983 action when they elect

to delay payment of medical bills pending the utilization review. Pet. App. 12a-19a. The Court remanded for further proceedings including class certification, addressing the issues of whether imposing the costs of reconsideration upon the losing party violates due process and whether the Commonwealth defendants have Eleventh Amendment immunity. Pet. App. 37a.

While the Third Circuit accurately reiterated the procedural posture which led to the School District's dismissal from the case and limited its holding to the state actor issue to the private insurance carriers, it seemed to infer that the School District may no longer contest its status as an alleged state actor. *See* Pet. App. 11a 14, 12a 16, 17a, 37a. It is respectfully submitted that the issues regarding the School District's status as a state actor remain undetermined in this matter consistent with the School District's position before the Third Circuit. School District Brief to Third Cir. n.6. Nevertheless, if the decision of the Court of Appeals is affirmed, in any part, and the case is remanded, issues regarding the School District's status and defenses to the Section 1983 action are preserved and will be addressed at the District Court level.

SUMMARY OF THE ARGUMENT

Pennsylvania's utilization review process accords sufficient due process to Pennsylvania claimants. The cost containment reform measures enacted by the Pennsylvania legislature do not operate to unconstitutionally deprive claimants of compensation benefits. Rather, the reform measures only extend the mandatory time period for payment of medical bills while those bills are reviewed for determination of whether the treatment provided was reasonable and necessary (*i.e.*, compensable under the Act).

Claimants are not unconstitutionally deprived of their benefits during the utilization review process, as the Third Circuit held. Only specifically challenged treatment, as opposed to all medical benefits, is subject to utilization review. Moreover, the process sufficiently balances the competing private interests of claimants and employers in Pennsylvania consistent with the test this Court set forth in *Mathews v. Eldridge*, 424 U.S. 319. The process protects any private interests claimants may have in the uninterrupted receipt of medical benefits because resolution of the compensability of the challenged treatment turns on a medical analysis and determination. During utilization review, all pertinent medical information is provided to the reviewer by the provider. The provider

may also furnish factual information as part of his/her medical records and has an opportunity for an oral consultation with the reviewer. The reviewer is required to follow well-defined procedures in conducting the review to determine only the reasonableness or necessity of the treatment, and the reviewer must be of the same specialty as the provider. Thus, any risk of an erroneous deprivation of medical benefits as a result of the institution of utilization review is slight.

The claimants' interest is further protected because tolling the period in which a bill must be paid in order to submit the bill for review affects neither the claimants' means of living nor their entitlement to other medical treatment from the health care provider subject to review or another health care provider of choice. The statute prohibits the medical provider from collecting any unpaid bills or balance from the Claimant and, the bill(s) must be paid immediately upon circulation of a reviewer's opinion that treatment is reasonable and necessary irrespective of any intentions by the employer or insurer to appeal the reviewer's determination. Full remedies exist which lessen the potential harm to claimants, such as the award of benefits, plus interest, where the claimant prevails on an appeal to a Workers' Compensation Judge.

The significant interests of Pennsylvania employers are protected because the tolling period pending review by the utilization review organization relieves the mandate of payment of unreasonable and unnecessary medical bills. The process, prior to the Third Circuit's *Sullivan* decision in March 1988, proved to be successful. As of February 1, 1997, the Bureau reported a twenty-five percent overall reduction in workers' compensation loss costs. Annual Report at ii. It was reported that the reform which sought to re-establish reasonable costs in a system that was out of control, while still serving the needs of legitimately injured claimants, was producing significant savings for the business community as a whole. Individual self-insured employers saved approximately $48,903,715 in medical compensation when comparing 1993 and 1996 statewide figures. *Id.* at 31.

The total medical compensation payment of insured and self-insured employers decreased 25% or $288 million, between 1993 and 1994 alone. *Id.* In short, the process was working to protect the legitimate governmental interests in containing Pennsylvania workers' compensation costs, preserving Pennsylvania jobs, and ensuring that medical benefits are paid to truly injured employees of the Commonwealth.

With respect to the sufficiency of the notice furnished to the claimants of the review, the process provides claimants with sufficient notice that their treatment is being challenged. Claimants are also provided with notice and an explanation of the appeal process when a determination is made as to the reasonableness and necessity of treatment. The notice provided is sufficient because due process, under the circumstances presented, merely requires that Claimants be notified that their treatment is under review and be provided a meaningful opportunity for hearing on the matter. *Cafeteria Workers v. McElroy*, 307 U.S. 886, 895 (1961) (due process is not a fixed concept with respect to time, place or circumstance).

Because no question is before the reviewer regarding the entitlement of a claimant to medical benefits in general and since a Claimant's entitlement to medical benefits will continue, there is no need for the employer, insurer, or Commonwealth to notify a claimant that medical benefits will be suspended as the Third Circuit held. When the determination is made that the specifically challenged treatment is not appropriate, claimants are notified at that time of the determination and of the proper channels to follow in order to contest the determination. Contrary to the Third Circuit's decision, notice in this case is sufficient, because the claimants are apprised of the review of treatment, the reviewer's determination and the method to secure a meaningful hearing.

The utilization review procedures further provide sufficient opportunity for claimants to participate in a meaningful hearing. Claimants are not deprived of due process because of the lack of an opportunity for either a hearing or an opportunity to submit a statement regarding the treatment prior to the reviewer's determination. Any such statement is neither valuable nor essential to the utilization review process. The doctor is the party to the process whose actions are being reviewed and the doctor, not the claimant, is in a much better position to discuss and persuade the reviewer to find that specific treatment is medically reasonable and necessary. Furthermore, the employer or insurer is precluded from submitting independent medical reports or other documentation to the reviewer. One would surely question the constitutionality of a system which would permit only the claimant and the claimant's doctor to participate, while the employer was precluded from submitting any documentation or provided any opportunity to participation in the utilization review process as it may now exist. Pennsylvania's utilization review system, as currently re-written by the

Third Circuit, works this very injustice. The Third Circuit's "revision" of the Act had a chilling effect on Pennsylvania cost containment initiatives. If this Court does not reverse the Third Circuit's decision, *in toto*, Pennsylvania will be strapped with a compensation system that is simply not workable and in fact, costs Pennsylvania more than the pre-reformed measures. The Act was amended in 1993 to replace the old review system with the utilization review process. Therefore, employers may no longer even petition a Judge directly for review of medical treatment. *See* 77 Pa. Stat. Ann. § 531(6) "[e]xcept in those cases in which a workers' compensation judge asks for an review under Section 420, disputes as to reasonableness and necessity of treatment . . . *shall* be resolved" by utilization review). [emphasis added, citation omitted].

Therefore, Pennsylvania employers and insurers must pay bills without remedy to recoup the funds when those bills are found to be unreasonable or unnecessary. Without a review petition, there is no supersedeas fund reimbursement and recouping the money from doctors or claimants is statutorily prohibited. If this Court rules as to the state actor issue alone, the effect of the Third Circuit's decision is that private employees insured through SWIF, "state actor" employees (including the Commonwealth and other public employers that may ultimately be classified as "state actors"), and private insurers would still be forced to pay the high cost of pre-reform medical expenses without remedy. State actor employers would be precluded from delaying the payment of bills during review and, therefore, lose any chance of avoiding payment for unreasonable and unnecessary treatment. Private employers insured through SWIF will realize those costs directly in their premiums, and private insurers who fund SWIF indirectly will also realize those costs. The providers will no longer have accountability under the Act and the costly abuse that existed prior to Act 44 will return in Pennsylvania.

Finally, as the District Court found, the assessment of a fee upon reconsideration review against a losing claimant does not violate due process. Plaintiffs' interest in uninterrupted workers' compensation benefits does not rise to the level of a "fundamental" right and employees have an alternative to judicial remedies which are not conditioned on the payment of fees. Claimants were simply not denied access to reconsideration, a Workers' Compensation Judge, or the appellate courts as a result of the subject reconsideration fee. See C.A. App. A156; 34 Pa. Code § 127.514(a).

Accordingly, the claims that the utilization review process does not comply with due process were properly dismissed by the District Court and the Third Circuit's decision should be reversed. The decisions of the District Court should be reinstated.

ARGUMENT

I. SELF-INSURED EMPLOYERS, LIKE PRIVATE INSURANCE COMPANIES, DO NOT BECOME STATE ACTORS WHEN THEY ELECT TO USE STATE AUTHORIZED UTILIZATION REVIEW PROCEDURES OR WITHHOLD PAYMENT TO HEALTH CARE PROVIDERS.

Self-insured employers, like private insurance companies, do not become "state actors" when utilization review is initiated and the payment of bills to health care providers is delayed pending a review of reasonableness and necessity of the treatment. *Blum v. Yaretsky*, 557 U.S. 991, 1007-1110 (1982) (state regulation of nursing homes does not convert actions of the homes into state action for purposes of due process); *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 350 (1974) (state regulation of public utilities does not convert the actions of the public utilities into state action for due process purposes). The Third Circuit erred in holding that state action is involved when private insurers decide to toll payments to medical providers for treatment pending utilization review.

The School District will not repeat the arguments in support of reversing the Third Circuit and affirming the decision of the District Court on the state actor issue fully and articulately addressed in the insurers' brief. However, it must be stressed that the identified compelling need for containment initiatives pertains equally to self-insured employers (both governmental and private) and private insurers in Pennsylvania. Likewise, the benefits and procedures contained in the utilization review process apply equally to Pennsylvania insurers and self-insured employers, whether governmental or private in nature. 77 Pa. Stat. Ann. § 5531 (5-6).

It is imperative that even if this Court decides that insurers and private self-insured employers are not state actors and that Summary Judgment should have been granted in the instant case, the Court must reach the issue of whether the Act, *as amended*, comports with the Fourteenth Amendment due process requirements. SWIF insures thousands of private employers in Pennsylvania. If this Court does not reach the due

process issue, not only will public employers be effected but the private employers insured through SWIF will be denied access to the cost containment benefit of utilization review. *See* Pa. Legis. J. — Senate 1044-1045 (approximately 450,000 employees working for approximately 35,000 employers were insured through SWIF).

The consequences will be that these entities will be forced to pay bills for treatment that may not be compensable with absolutely no remedy or ability to recoup the value of these costs. The hardship on Pennsylvania employers is great and weighs heavily, considering the stated governmental interest in containing costs which prompted Pennsylvania workers' compensation reform to stop the exodus of jobs to other states. This issue should not be passed over by this Court.

II. THE UTILIZATION REVIEW PROCESS IN PENNSYLVANIA'S WORKERS' COMPENSATION SYSTEM COMPORTS WITH CONSTITUTIONAL DUE PROCESS.

A. Claimants failed to establish a governmental deprivation of a constitutionally protected right.

Rights secured by the constitution are generally protected only against infringement by government. *Lugar v. Edmonson Oil Co.*, 457 U.S. 992, 936 (1982). To trigger the Fourteenth Amendment's procedural protection regarding the due process rights, an individual must have suffered a deprivation of a protected property interest by the government or a private entity deemed to be a state actor. *Id.*

The remedy for a deprivation of a right secured by the Constitution and laws of the United States is provided under Title 42 U.S.C. § 1983. To bring a claim under Section 1983, a plaintiff must establish that he or she was deprived of a federally-protected right and that the conduct allegedly causing the deprivation can be fairly attributable to the State. *See Lugar* at 937 (1982). A Section 1983 plaintiff must also prove that it was the defendant who subjected him or her to the alleged deprivation or otherwise caused the deprivation. *Collins v. City of Harker Heights*, 503 U.S. 115 (1992).

Even if self-insured employers or private insurers are determined to be state actors, Plaintiffs simply have not established the requisite deprivation of a constitutionally protected right during the utilization review process. Pennsylvania claimants are simply not denied treatment at the hands of the employers, insurers or even the Commonwealth during the utilization review process. The decision whether to continue

specifically challenged treatment is left to the treating physician. As the record shows, some physicians continue treatment while others do not.[11] C.A. App. A99, A100, A107, A108-A109, A113. Because tolling payment is not the equivalent of ceasing treatment, the Circuit Court erred in defining and weighing claimants' interest under the *Mathews* test.

The Plaintiffs' challenge to invocation of utilization review by the employer or insurer pertains only to the payment of bills for treatment already provided. Thus, any choice to discontinue ongoing treatment during the review would rest with the treating physician. This provision operates to keep the treating physicians accountable and presumably, if the provider truly believes the treatment is appropriate, treatment will continued. *See*, *Pennsylvania Medical Practice Act*, 77 Pa. Stat. Ann. § 422.1, *et. seq.*; American Medical Ass'n. Report on Ethics, *infra*, n7.

The process does not "suspend" the Plaintiffs' right to all medical benefits as the Third Circuit indicated. Rather, the regulations only allow the employer to toll payment of specific bills for a limited time frame while the bills are subject to utilization review. 34 Pa. Code § 127.208. The regulations direct the employer or insurer to pay those bills if it is determined that the bills are compensable under the Act irrespective of any intentions to challenge further by way of reconsideration review before the Workers' Compensation Judge or appeals to the Workers' Compensation Appeal Board or appellate courts. 34 Pa. Code § 127.208(f). Consequently, where treatment is found to be reasonable and necessary, no suspension or deprivation of benefits takes place at all.[12]

It is when the reviewer determines that the bills pertain to treatment that is not reasonable or necessary that an opportunity for a limited suspension of benefits arises. However, at that juncture, claimants are

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11. As the Commonwealth pointed out in its brief to the Third Circuit, the second private interest is present even when SWIF is the insurer. Although SWIF is created by statute and operated by the State, it insures private employers who pay for the coverage provided. 77 Pa. Stat. Ann. §§ 2221, 241, 283, 301 (West Supp. 1992).

12. Consideration must be given to the Legislative power to se the reasonable time frames during which bills must be paid. The Pennsylvania Legislature could have merely extended the time to pay medical bills to ninety days, allowing time for utilization review. However, then payment of unchallenged treatment could have been delayed and no parties interest would have been served. therefore, the extension of the time period to pay bills pending review is sensible and serves both the interests of claimants and employers.

provided notice that the treatment is not reasonable or necessary and an opportunity for a hearing. 34 Pa. Code § 127.472. Specifically, the reviewer's decision is required to explain the basis for his/her opinion that the treatment has been determined to be unreasonable and unnecessary. *Id.* The review organization must also provide forms for petitioning for further review or reconsideration in pre-Act 57 matters.[13] 34 Pa. Code § 127-476. At the hearing, claimants have an opportunity to present evidence and cross-examine witnesses in order to attempt to have the payments for specific treatment reinstated. Following a workers' compensation judge's decision, the parties have a right to full administrative and judicial review by the Workers' Compensation Appeal Board and Commonwealth Court of Pennsylvania. 77 Pa. Stat. Ann. §§ 531(6)(iv), 701, 42 Pa. CS § 751.

As this Court recognized, constitutionally adequate process is afforded by statutes when reasonable remedies exist to correct errors of administrative bodies in determining rights regarding protected interest. *Bello v. Walker*, 840 F.2 1124, 1128 (3rd Cir.), *cert denied*, 488 U.S. 851 (1988) (the provisions of subsequent process to challenge the denial of a building permit satisfy due process). It is submitted that the utilization review process is adequate, especially in light of the immediate right to review of the utilization reviewer's determination and the remedies available under the Act if payment for treatment is ultimately reinstated. 34 Pa. Code §§ 127.501, 127.502.

B. The Process Provides Claimants Sufficient Notice

Contrary to the Third Circuit's misperception of the utilization review process, any alleged governmental deprivation or termination of medical benefits does not occur as a result of invocation of utilization review. It is not until after the utilization review process is invoked and the utilization review determination is rendered, where employers are entitled to a limited suspension of benefits. *See* 77 Pa. Stat. Ann. 531(6); 34 Pa. Code § 127.208. Thus, the process provides claimants with sufficient meaningful notice during review to keep them apprised of the challenge to treatment and an opportunity for hearing as of the time of the suspension. *See* 34 Pa. Code § 127.208 (mandatory time to pay bills is tolled when submitted to utilization review, and employers are entitled

13. Pre Act 57, claimants had an opportunity to state their position regarding treatment on the petition for reconsideration. Claimants could indicate on the form why they believe the treatment is reasonable and necessary.

to continue a suspension of benefits for the limited treatment upon a determination of unreasonable or unnecessary care).

Specifically, the claimants are notified that the employers or insurers have invoked the utilization review process pursuant to 34 Pa. Code § 127.452 to specifically request review of the reasonableness and necessity of care. *See* C.A. App. B34. The claimant and employer also receive a notice of assignment of utilization review. C.A. App. B35. The notice of assignment again informs the claimant that the reasonableness and necessity of specific medical treatment is being reviewed and that the medical provider must send relevant medical records within thirty days. 34 Pa. Code § 127.453(b).

The Third Circuit states that this notice is not sufficient because the employee is not told that his medical benefits may cease pending review. However, again, at no time during the utilization review process is any factfinder empowered to make determinations as to the causal connection between the treatment and the work injury; whether a claimant has achieved maximum medical improvement; or whether entitlement to medical benefits should otherwise continue. 34 Pa. Code §§ 127.470, 127.471. Because claimants' general entitlement to medical benefits is never at issue, the claimants' right to medical benefits are not "terminated" during review and the notice provided to the claimants need not indicate that benefits may "cease" as the Third Circuit required.

Because claimants' entitlement to medical benefits, generally, continues during utilization review, and it is the treating physicians who will know if they are practicing outside ordinarily accepted protocol, it will be the treating physician who, based upon their own personal knowledge, will decide whether to continue treatment. Of course, the physicians remain free to initiate any other type of treatment or methods of treatment that are more appropriate in order to continue being paid for services. Additionally, nothing in the Act prohibits the claimants from directly paying the doctors for services after it is finally adjudicated that services are outside the parameters of the Act.

The Third Circuit also took issue with the initial request for utilization review and notification of assignment to a utilization review organization as not providing sufficient information or explanation concerning what the utilization review process involves for claimants to understand and participate in the process. Pet. App. 21a-25a. Nevertheless, the initial requests for utilization review and initial assignment notifications provide sufficient notice to the claimants of the challenge to their treatment.

Mullane v. Central Hanover Bank and Trust Co., 339 U.S. 306 (1950) (notice need only apprise interested parties of the pendency of an action and afford them an opportunity to participate at a meaningful time). Because there is no meaningful input which claimants could provide at that juncture in the review process, this notice is sufficient.

The determination will be made by a reviewer upon consideration of medical records and any information provided by the provider (whose payment hinges upon his cooperation) with respect to how the treatment helps a claimant. The provider is the best source for this information and is provided the opportunity to submit records, talk to the reviewer, and persuade the reviewer of the medical basis or bases for a determination that the treatment is reasonable and necessary. Since the payments are issued to the provider, not the claimant, a provider treating within acceptable parameters has a financial incentive to comply in order to secure payment of his/her bills. One must question the appropriateness of treatment by a provider who simply does not comply with the reviewer's request for information.

Moreover, the Third Circuit's determination that the notice was insufficient turned primarily on the decision on the United States District Court for the Eastern District of Pennsylvania in the case of *Baksalary v. Smith*, 579 F. Supp. 218 (E.D. Pa. 1984), *aff'd*, 772 F.2d 893 (3d Cir. 1985), *cert. denied*, 469 U.S. 1146 (1985). However, not only was that decision erroneously decided by the District Court and its holding should be overruled by this Court, that process is inapposite to the one presented here.[14]

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14. In *Baksalary*, a challenge to a portion of former Section 413(a) of the Workers' Compensation Act was addressed, which allowed an automatic supersedeas of all workers' compensation benefit payments under the Act. The supersedeas was "automatic" upon the filing of a petition to terminate benefits that alleged either the employee returned to work at the same or greater rate of pay, or that the employee had completely recovered from his work-related injuries. *Baksalary*, 579 F. Supp. at 221. To obtain a supersedeas on the latter ground, the petition had to be filed within 15 days of an examination, and a physician's affidavit addressing the recovery was required to be attached. *Id.* The supersedeas remained in effect until the termination petition was fully litigated.

The *Baksalary* Court ruled that Section 413(a) violated due process in that a claimant was not given notice of the supersedeas nor an opportunity to respond to the physician's affidavit. *Id.* at 232-33. The concurring opinion (Cont'd)

In *Baksalary*, the District Court determined that when a self-insured employer or insurance company terminated a claimant's benefits based upon a doctor's opinion establishing that payment of compensation is longer warranted, and merely notified the state of that action, the insurer or employer became a state actor and the claimant's constitutionally protected property interest in the workers' compensation indemnity benefits was violated under the Fourteenth Amendment to the United States Constitution. The *Baksalary* holding has been rejected by the Fifth Circuit in *Barns v. Lehman*, 861 F.2d 1383 (5th Cir. 1988). In that decision, the Fifth Circuit explicitly declined to "embrace the reasoning of *Baksalary*" holding that "procedural regulations simply do not suffice to establish the degree of joint participation required to convert private action into state action." 861 F.2d 1387. Similar procedures allowing for termination of benefits based solely upon a doctor's report expressing

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(Cont'd)

concluded that due process was violated by insufficient notice and the insufficient guarantee of decision maker impartiality. *Id.* at 236-237.

Nevertheless, the Third Circuit's reliance on *Baksalary* in this case was misplaced. *Baksalary* involved a provision wholly distinguishable from the provision challenged in the instant case. The concerns which lead to the invalidation of Section 413(a) in *Baksalary* do not exist here. The utilization review process significantly narrower and contains "checks and balances" which afford greater due process protection than the former Section 413(a). The scope and nature of the current provisions ensure impartiality and integrity of the "reasonable or necessary" determination.

First, the only benefits subject to utilization review and possible suspension of payment relate to specific medical treatment. 34 Pa. Code §§ 127.401, 127.402. Other medical utilization benefits and wage replacement benefits are not subject to utilization review or possible suspension under the subject provisions. Under the former Section 413(a), all benefits, including wage benefits, which often provide the employee's sole means of subsistence, were subject to the automatic supersedeas.

Furthermore, the automatic supersedeas under Section 4139a) remained in effect until the matter was fully litigated. Prior to Act 57, if a decision in favor of the treatment was made at the initial review, payment of benefits was required unless the insure or employer sought reconsideration. 34 Pa. Code § 127.208. If the insurer or employer lost again on reconsideration, payment was required regardless of whether further review was sought. *Id.* Act 57, which eliminated the reconsideration process, requires payment to be made if the treatment is upheld at the initial review regardless of whether a petition for review is filed.

an opinion that benefits were no longer compensable were also adopted by the Fourth Circuit in the case *Fleming v. Workers' Compensation Commission of the Commonwealth of Virginia*, 878 F.2d 852 (E.D. Va. 1995), *aff'd mem.*, 78 F.3d 578, *reported in full*, 1996 U.S. App. LEXIS 3858 (4th Cir. Mar. 5, 1996).

In the *Fleming* case, the Fourth Circuit recognized that Virginia law permitted insurers to suspend payment of benefits immediately upon filing an application with the state challenging the entitlement to benefits. The Court recognized that the ultimate decision to stop payment of benefits rested with the insurer who was not a state actor and simply complied with the procedures and exercised its options in compliance with the state's statute.

In the matter sub judice, benefit entitlement is not at issue as it was in *Baksalary*. Moreover, claimants receive sufficient notice of the status of the review at meaningful times and the notifications provide claimants sufficient information with respect to how and when they can participate in a meaningful way. Thus, due process requirements are satisfied.

There is no reason why the employer or insurer should have to pay for treatment that is not reasonable or necessary once the reviewer determines the treatment is outside accepted protocol. The post-review determination hearings provide satisfactory safeguards against erroneous deprivation.

C. Utilization Review Procedures Satisfy Due Process

It is axiomatic that the concept of due process is flexible, focused on ensuring "fundamental fairness" in decision making. *Walters v. National Ass'n of Radiation Survivors*, 473 U.S. 305, 320 (1985). Not being a technical concept, due process is not fixed with respect to time, place or circumstance. *Cafeteria Workers v. McElroy*, 367 U.S. 886, 895 (1961).

> Procedural due process imposes constraints on governmental decisions which deprive individuals of "liberty" or "property" interests within the meaning of the Due Process Clause of the Fifth or Fourteenth Amendment.

Mathews v. Eldridge, 424 U.S. 319, 331 (1976).

The process required varies depending on the nature of the interests at issue and the circumstances under which deprivation may occur. *Walters* at 320; *Morrisey v. Brewer*, 408 U.S. 471, 481 (1972). Nevertheless, "legislatures are to be allowed considerable leeway to

formulate such processes without being forced to conform to a rigid constitutional code of procedural necessities." *Walters*, at 326.

Whether specific procedures satisfy due process is a legal question for the Court to resolve. *Midnight Sessions, Ltd. v. City of Philadelphia*, 945 F.2d 667, 684 (3d Cir. 1991) *cert. denied*, 503 U.S. 54 (1992). In conducting a due process inquiry, Courts must balance three factors: (1) the private interests that will be affected by the official action; (2) the risk that the procedures will result in an erroneous deprivation of the interest and the probable value of additional procedures; and, (3) the governmental interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail. *Mathews*, 424 U.S. at 334-335. Applying these factors herein, it is evident that the Pennsylvania legislature enacted an administrative scheme which provides sufficient due process to workers' compensation claimants.

a. Private Interests

Unlike the circumstances presented in *Mathews*, where only one private interest was at issue, the instant case involves two opposing private interests. The District Court correctly defined the private interest of plaintiffs herein as their "desire for uninterrupted receipt of [medical] benefit[s] pending the final administrative decision on their cases." C.A. App. A29. This "interest" is tempered by the fact that Pennsylvania's Workers' Compensation law entitles claimants to retroactive relief, interest and costs if challenged medical treatment is ultimately found, in later proceedings, to be reasonable and necessary. 77 Pa. Stat. Ann. § 717.1, 996; *see also Mathews* at 340; *Cryder v. Oxendine*, 24 F.3d 175, 178 (11th Cir. 1994) (holding that the potential harm to the individual employee is less under Georgia's workers' compensation act, because of the availability of full retroactive relief).

Additionally, eligibility for workers' compensation medical benefits is not based upon financial need and will not deprive the plaintiffs of their means to live as was the case in *Mathews*. As the District Court found, claimant's interests in uninterrupted payment of medical bills is, therefore, further tempered by the fact that claimants have access to additional financial resources such as wage replacement monies or other sources. "[C]laimants may have support from many other sources, 'such as earnings from other family members, workmen's compensation awards, tort claim awards, savings, private insurance, public or private

pensions, veteran benefits, food stamps, public assistance . . .' ". C.A. App. A29, (citing *Mathews*, 424 at 341-342). In fact, while the Act prohibits a doctor from billing an employee directly, nothing in the statute indicates that a claimant is prohibited from reimbursing the medical provider at the end of the administrative process if, in fact, the bills are for services that are found to be outside the compensability provided for in the Act. C.A. App. A30 n4.

Although the Third Circuit cited *Mathews* for the proposition that the interest claimants have is in the uninterrupted receipt of medical benefits, in its analysis, the Third Circuit actually applied the following interest: "interest in the relief that the medical treatment provides to the injured Employees." Pet. App. at 36A. The Third Circuit's abandonment of the *Mathews* analysis is evident from the Circuit Court's criticism that the District Court mischaracterized the nature of claimants' interests. The Circuit Court observed that the District Court viewed these interests as a pecuniary in nature and not interests in the relief that the medical treatment provides. Thus, the Third Circuit actually shifted the focus of the interest to be weighed and expanded the very nature of the benefits Pennsylvania claimants are entitled to receive. The Act does not guarantee all claimants the unqualified right to any treatment they wish with whatever frequency they desire for the duration they choose. Rather, the Act allows only for the payment of reasonable and necessary medical treatment causally related to the work injury.

On the other hand, it cannot be ignored that private insurers and employers have an equally significant interest in not paying for medical treatment that is unreasonable or unnecessary. The Third Circuit completely ignored, without comment, the argument that it must also weigh the interests of insurers and self-insured employers (both governmental and private) in determining and weighing the interests at stake. This second interest is heightened by the inability to recoup any payments for treatment ultimately found to have been neither reasonable or necessary. *See Moats v. Workmen's Compensation Appeal Board*, 588 A.2d 116, 118 (Pa. Cmwlth. 1991). Insurers may only seek to recover from the Supersedeas Fund, which insurers fund themselves and which does not pay interest. 77 Pa. Stat. Ann. § 999; *Liberty Mut. Liab. Ins. Assoc. v. Workmen's Compensation Appeal Board*, 537 Pa. 367, 644 A.2d 697 (1994).

In short, the procedures in place adequately protect the interest of claimants. It is also indisputable that the employers' interests are

heightened and are not tempered by the same type of protection and relief the procedures otherwise afford claimants. It is respectfully submitted that adequate procedural protections are provided by the utilization review process to protect the interests of the plaintiffs against any risk of erroneous deprivation. Because the plaintiffs are granted post review relief and remedies, their interests pale in comparison to the heightened interests that employers and insurers have in not making payments for unreasonable and unnecessary treatment.

b. Risk of Erroneous Deprivation and Alternate Procedures Would Be of No Value

The risk of erroneous deprivation is slight when considering the utilization review system and procedures in place in the workers' compensation system as a whole. The process of utilization review contains numerous "checks and balances" protecting against arbitrary analyses and decisions.

None of the parties, including the insurer or employer, select the reviewer. This provision safeguards the impartiality of the process. 34 Pa. Code § 127.466.

Further securing the integrity of the review determination, the process requires the utilization review organization to assign the utilization request to a reviewer in the same profession and having the same specialty as the medical provider under review. 34 Pa. Code § 127.466. Reviewers are required to apply generally accepted treatment protocol to the case 34 Pa. Code § 127.467. These protocols are to be applied by reviewers in determining "whether the treatment under review is reasonable or necessary for the medical condition of the employee." 34 Pa. Code § 127.470(a). Reviewers must assume that the injuries are work-related, and are prohibited from addressing issues such as current disability status, quality of care, fee reasonableness or whether maximum medical improvement has occurred. 34 Pa. Code § 127.470(b).[15]

15. The provisions on the authorization of utilization review organizations are intensive, ensuring the impartiality of the qualified reviewers utilized and the integrity of the utilization review process. *See* 34 Pa. Code §§ 127.651-670. The Bureau retains the power to suspend the assignment of new reviews to a utilization review organization not performing its responsibilities under the Act, and may revoke a utilization review organization's authority to perform reviews. 34 Pa. Code §§ 127.668, 127.669. The close monitoring of utilization review organizations is another example of the protections which reduce the risk of an erroneous deprivation.

The risk of erroneous deprivation is further minimized because the "reasonable or necessary" decision is a medical determination based upon unbiased medical reports. The Supreme Court has classified medical reports as "routine, standard and unbiased", containing "reliability and probative worth" without the "specter of questionable credibility and veracity". *Richardson v. Perales*, 402 U.S. 389, 407 (1971); *see also Mathews* at 344. In rendering a utilization review decision, the reviewer consults with the provider under review, considers the records and reports of said provider and possibly other treating providers. 34 Pa. Code §§ 127.459, 127.460, 127.469. The veracity of such materials confirms that sufficient due process is provided.

The above described limitations imposed upon reviewers under the Act reflect protection against erroneous decisions beyond those provided in the statutory Social Security disability scheme upheld in *Mathews*. In *Mathews*, the government could terminate disability benefits based solely upon the report of its own independent medical examiner, as opposed to reports by the claimant's treating physician. Pennsylvania's scheme, in contrast, prohibits a utilization review organization from obtaining, and/or a reviewer from reviewing, reports of independent medical examinations. 34 Pa. Code § 127.461 (limiting the scope of records that can be reviewed to records of actual treating health care providers).

Stated another way, unlike the government in *Mathews*, Pennsylvania insurers or employers cannot impact the ultimate outcome of a utilization review. The challenged procedures are non-adversarial and are based solely on a claimant's "side of the story". The utilization procedures provide more due process protection than the scheme upheld in *Mathews*.

The same conclusion is reached upon an examination of *Parham v. J.R.*, 442 U.S. 584 (1979). In *Parham*, this Court reviewed for due process compliance, the State of Georgia's procedures for the voluntary commitment to state mental institutions of children by their parents. Georgia state law empowered the superintendent of the subject institution to assess the child's mental state and determine whether hospital care would likely benefit the child. *Id.* at 605. The state procedures did not provide for a formalized factfinding, judicial or administrative hearing at any stage.

This Court upheld the state procedures. In rejecting the argument that due process required a hearing, the Court emphasized that due process was satisfied where a staff physician, acting independently and utilizing traditional medical techniques, rendered decisions on treatment. *Id.* at

607. The Court, in emphasizing the medical nature of the decision in that case, noted that "[n]ot every determination by state officers can be made most effectively by use of 'the procedural tools of judicial or administrative decision making.' " *Id* at 608 (*quoting Board of Curators of Univ. of Missouri v. Horowitz*, 435 U.S. 78, 90 (1978)).

The process challenged in the instant case is similar to *Parham* in that both cases involve a medical determination. The Pennsylvania process contains subsequent procedures involving petitions for a hearing de novo before a Workers' Compensation Judge where treatment is found to be unreasonable and unnecessary and appeals to the appellate courts of Pennsylvania, as of right, if the claimant is dissatisfied with the results of the de novo hearing. 42 Pa. C.S. § 761. The Court in *Parham* held that the Georgia scheme comported with due process, despite lacking similar subsequent procedures to correct an erroneous decision.

The Third Circuit found that the risk of an erroneous deprivation was great because claimants did not have an opportunity to submit a statement indicating, subjectively, how the treatment helps them. However, any relief or benefit treatment provided a claimant would be documented in the doctor's records and the doctor is given an opportunity to discuss the treatment with the reviewer. Since medical reports are unbiased, objective and trustworthy, problems associated with the credibility of witnesses are not present. *See Matthews*. Therefore, an opportunity for a hearing or written submission by a claimant as to how they believe the treatment helps, would not aid in avoiding erroneous decisions and would be of no value. *See, Parham; Horowitz*.

Plaintiffs suggest that an erroneous deprivation may occur due to the complete or partial non-responsiveness of a provider under review acting counter to a claimant's interests. However, they fail to support this contention with anything other than their broad suppositions. The record is devoid of any averments to support the scenarios claimed in their brief and demonstrate a "risk" of an erroneous deprivation. The slight chance that an erroneous decision may occur under unsubstantiated circumstances is an insufficient ground upon which to find process unconstitutional. Procedural due process rules "are shaped by the risk of error inherent in the truthfinding process as applied to the generality of cases, not the rare exceptions." *Mathews* at 344. This slight risk is tempered by the subsequent procedures provided for review de novo through which any errors can be rectified.

In short, the current provisions provide sufficient due process protection against the risk of erroneous deprivation of specific medical benefits pending utilization review. Under *Mathews*, due process does not require hearing prior to the insurer/employer's suspension of payment of the challenged treatment.

c. Governmental Interest

Under *Mathews*, the governmental interest involved must be factored into the due process analysis. The Commonwealth of Pennsylvania has an interest in ensuring that the payment of medical benefits occurs for only truly disabled employees. This interest is protected by the establishment of a fair and efficient workers' compensation system. The public shares in this interest, because when Pennsylvania insurers or self-insureds pay for unreasonable or unnecessary medical treatment, these costs are passed to the Pennsylvania consumer.

The government also has an interest in containing the medical costs in workers' compensation. Cost-containment reduces, among other things, insurance premiums in the Commonwealth which increases the likelihood that employers and insurers will remain in business in Pennsylvania.[16] Adding an evidentiary hearing to the utilization review process would only increase costs and frustrate the governmental interests.

d. The Interest Balance Weighs in Favor of the Sufficiency of the Utilization Review Process

In assessing what process is due, substantial weight should be accorded to the good faith judgment of the Pennsylvania Legislature and those individuals the Legislature have charged to administer the Workers' Compensation system and the procedures they developed to assure fair consideration of the reasonableness and necessity of medical treatment provided to claimant. *See Mathews* at 348 (affording Congress and those charged thereby substantial weight in their good faith judgments in providing the Social Security Claims entitlement procedures). Substantial

16. The remarks made in the Senate during the debate over whether to adopt Senate Bill No. 1 (later Act 44) reveal that concerns over employers fleeing Pennsylvania's high workers' compensation costs fueled the drive towards the legislation. Senator Madigan, who spearheaded the passage of the bill, expressed the legislature's task as seeking to "achieve a public policy that will encourage employers and jobs to stay in this Commonwealth." Pa. Legis. J. — Senate 284 (February 10, 1993).

weight should be given in light of the fact that the procedures not only provide claimant with protection against erroneous decisions regarding their treatment, they also assure a right to an evidentiary hearing and subsequent judicial review before a denial of a claim becomes final. *Id.*; *see Boddie vs. Connecticut*, 401 U.S. 371, 378 (1971).

The utilization review system sufficiently strikes the necessary balance of protecting the significant interests of the government, employers and private insurers while also protecting the private interest of claimants. Therefore, the utilization review process is constitutionally sound.

D. Imposing reconsideration costs upon the losing party does not violate due process.

Plaintiffs also challenged the constitutionality of the imposition of reconsideration costs under Act 44. The District Court properly rejected Plaintiffs' contention that this provision contravened due process.

Due process is not contravened because the instant case does not involve any fundamental right or interest similar or analogous to those in cases where this Court held that the imposition of fees amounted to a denial of constitutional due process. In *Boddie*, welfare recipients challenged certain Connecticut procedures, including those requiring the payment of filing fees and costs, as a violation of due process. The plaintiffs, claiming indigence, asserted that the filing fees unduly restricted their access to the courts. The Court held that a state could not, consistent with due process, pre-empt the right to dissolve a marriage "without affording all citizens access to the means it has prescribed for doing so." *Id.* at 382-383. The Court reasoned that because the state required its citizens to resort to the state judicial process as "the exclusive precondition to the adjustment of a fundamental human relationship," mandatory court filing fees which precluded indigent access were violative of due process. *Id.* This Court thus recognized one's right to determine marital status as fundamental.

Similarly, in *Little v. Streater*, 452 U.S. 1 (1981), this Court held that the imposition of the cost of blood tests on an indigent party contesting a paternity action was violative of due process. The Court recognized the "constitutionally significant" interest the petitioner had in contesting paternity. *Id.* at 13, 16, n.12. *Little* recognized and protected the individual interest in parental status.

In the instant case, Plaintiffs' desire for uninterrupted receipt of medical benefits does not rise to the level of the interests recognized in

Boddie and *Little*. Instead, Plaintiffs' interest is comparable to the interests of the respective plaintiffs in *United States v. Kras*, 409 U.S. 434 (1973) and *Ortwein v. Scwab*, 410 U.S. 656 (1973). In these cases, the Supreme Court determined that no fundamental right was at issue and upheld the challenged filing fee provisions.

In *Kras*, the Supreme Court upheld statutorily imposed bankruptcy filing fees against a claim brought by an indigent, who alleged that the fee requirement violated their right to constitutional due process. Applying *Boddie*, this Court stated that one's interest in a bankruptcy discharge "does not rise to the same constitutional level" as one's inability to dissolve a marital relationship through the state-mandated judicial process. *Kras* at 445.

In *Ortwein*, the Supreme Court upheld the Oregon appellate filing fee applied to an indigent seeking to appeal an adverse welfare decision. In rejecting petitioners' due process argument, the Court declared that petitioners' interest in increased welfare payments "has far less constitutional significance than the interest of the *Boddie* appellants." *Ortwein* at 659.

The interests of Plaintiffs herein "was far less constitutionally significant than the interest of the *Boddie* appellants." *Id.* While important, the desire for uninterrupted medical benefits is not a fundamental right. *See School Dist. of San Antonio v. Rodriguez*, 411 U.S. 1, 33 (1973) (limiting "fundamental" rights to those explicitly or implicitly guaranteed by the Constitution). Plaintiffs' interest is more akin to those interests in *Kras* and *Ortwein*, which were not given constitutional deference. *Cf. Bullock v. Carter*, 405 U.S. 134 (1972) (right to run for public office is a fundamental right); *Williams v. Rhodes*, 393 U.S. 23 (1968) (right to vote is a fundamental right); *Shapiro v. Thompson*, 394 U.S. 618 (1969) (right to interstate travel is a fundamental right); *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535 (1942) (right to procreate is a fundamental right).

The costs of the initial utilization review are incurred by the employer or insurer. 77 Pa. Stat. Ann. § 531(6)(iii) (West Supp. 1996). Prior to Act 57, if reconsideration was sought, the costs thereof were advanced by the Bureau and the losing party was subsequently billed. 34 Pa. Code § 127.514(a). The losing party was required to reimburse the Bureau within 30 days. *Id.* However, payment of the costs imposed was not required before the losing party could file a petition for review before a Workers' Compensation Judge or subsequent appeals to the Pennsylvania

courts. Thus, the cost obligation does not preclude an employee from pursuing his/her claims through administrative procedures and the courts.

The imposition of reconsideration costs also does not amount to a judgment which the losing party may be compelled to satisfy under law. All that the challenged provisions allowed was the forwarding of a bill for the utilization review organization's charge from the Bureau to the losing party. *Id.* at §127.514(a). Before a party could be compelled to pay, the Bureau would have to obtain and execute upon a judgment pursuant to the Pennsylvania Rules of Civil Procedure. *See* Pa. R. Civ. P. 1001-1041.2, 3101-3149. The Rules of Civil Procedure provide the losing party with more than an adequate opportunity to contest its liability for the costs. *See* Pa. R. Civ. P. 1017, 1028, 1029, 1030.

In sum, Act 44 did not violate due process by imposing reconsideration costs upon the losing party.[17]

CONCLUSION

The judgment of the United States Court of Appeals for the Third Circuit should be reversed and the judgments of United States District Court Judge Buckwalter reinstated.

Respectfully submitted,

JAN M. RITCHIE
Counsel of Record
JAMES M. TYLER
PATRICIA FARRELL KERELO
JOSEPH W. CUNNINGHAM
MARK PFEIFFER
SCHUBERT, BELLWOAR, CAHILL & QUINN
Attorneys for Respondent School District of Philadelphia
1500 John F. Kennedy Blvd.
Suite 1400
Philadelphia, PA 19102
(215) 587-0146

17. The Third Circuit determined that the regulations governing the utilization review provides sufficient standards and guidance to comport with due process. Plaintiffs have not challenged that determination before this court and thus the School District need not address that issue.